

SYSTEM AUTHORIZATION ACCESS REQUEST (SAAR)

PRIVACY ACT STATEMENT

AUTHORITY: Executive Order 10450, 9397; and Public Law 99-474, the Computer Fraud and Abuse Act.
 PRINCIPAL PURPOSE: To record names, signatures, and Social Security Numbers for the purpose of validating the trustworthiness of individuals requesting access to Department of Defense (DoD) systems and information. NOTE: Records may be maintained in both electronic and/or paper form.
 ROUTINE USES: None.
 DISCLOSURE: Disclosure of this information is voluntary; however, failure to provide the requested information may impede, delay or prevent further processing of this request.

TYPE OF REQUEST <input type="checkbox"/> INITIAL <input type="checkbox"/> MODIFICATION <input type="checkbox"/> DELETION <input type="checkbox"/> USER ID _____		DATE (YYYYMMDD)
SYSTEM NAME (Platform or Applications)		LOCATION (Physical Location of System)

PART I (To be completed by Requestor)

1. NAME (Last, First, Middle Initial)		2. SOCIAL SECURITY NUMBER
3. ORGANIZATION	4. OFFICE SYMBOL/DEPARTMENT	5. PHONE (DSN or Commercial)
6. OFFICIAL E-MAIL ADDRESS	7. JOB TITLE AND GRADE/RANK	
8. OFFICIAL MAILING ADDRESS	9. CITIZENSHIP <input type="checkbox"/> US <input type="checkbox"/> FN <input type="checkbox"/> OTHER	10. DESIGNATION OF PERSON <input type="checkbox"/> MILITARY <input type="checkbox"/> CIVILIAN <input type="checkbox"/> CONTRACTOR

USER AGREEMENT

I accept the responsibility for the information and DoD system to which I am granted access and will not exceed my authorized level of system access. I understand that my access may be revoked or terminated for non-compliance with DoD security policies. I accept responsibility to safeguard the information contained in these systems from unauthorized or inadvertent modification, disclosure, destruction, and use. I understand and accept that my use of the system may be monitored as part of managing the system, protecting against unauthorized access and verifying security problems. I agree to notify the appropriate organization that issued my account(s) when access is no longer required.

IA TRAINING AND AWARENESS CERTIFICATION REQUIREMENTS (Complete as required for user or functional level access.)

☐ I have completed Annual Information Awareness Training. DATE (YYYYMMDD) _____

11. USER SIGNATURE	12. DATE (YYYYMMDD)
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PART II - ENDORSEMENT OF ACCESS BY INFORMATION OWNER, USER SUPERVISOR OR GOVERNMENT SPONSOR (If individual is a contractor - provide company name, contract number, and date of contract expiration in Block 16.)

13. JUSTIFICATION FOR ACCESS

14. TYPE OF ACCESS REQUIRED: <input type="checkbox"/> AUTHORIZED <input type="checkbox"/> PRIVILEGED

15. USER REQUIRES ACCESS TO: <input type="checkbox"/> UNCLASSIFIED <input type="checkbox"/> CLASSIFIED (Specify category) <input type="checkbox"/> OTHER _____

16. VERIFICATION OF NEED TO KNOW I certify that this user requires access as requested. <input type="checkbox"/>	16a. ACCESS EXPIRATION DATE (Contractors must specify Company Name, Contract Number, Expiration Date. Use Block 27 if needed.)
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17. SUPERVISOR'S NAME (Print Name)	18. SUPERVISOR'S SIGNATURE	19. DATE (YYYYMMDD)
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20. SUPERVISOR'S ORGANIZATION/DEPARTMENT	20a. SUPERVISOR'S E-MAIL ADDRESS	20b. PHONE NUMBER
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21. SIGNATURE OF INFORMATION OWNER/OPR	21a. PHONE NUMBER	21b. DATE (YYYYMMDD)
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22. SIGNATURE OF IAO OR APPOINTEE	23. ORGANIZATION/DEPARTMENT	24. PHONE NUMBER	25. DATE (YYYYMMDD)
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